Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ERGONOMIC REHABILITATION OF HOUSTON 283 LOCKHAVEN DRIVE SUITE 315 HOUSTON, TX 77073	MFDR Tracking #: M4-07-1950-02 DWC Claim #: Injured Employee:
Respondent Name and Box #: STATE OFFICE OF RISK MANAGEMENT Box #: 45	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our charges for the disputed dates of service were denied based on code 505. The explanation of the insurance company for this reason is maximum units exceeded. According to CMS Physical Medicine and Rehabilitation Guidelines, the usual treatment session provided in the home or office setting is 45 to 60 minutes. The medical necessity of services for an unusual length of time must be documented as described in the "Documentation Requirements" section of this policy. Coverage and medical necessity for physical therapy guidelines state the medical necessity of services being provided for a period longer than two hours must be documented."

Amount in Dispute: $645.48

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This will acknowledge receipt of the Medical Dispute on the above referenced claim by the State Office of Risk Management (Office). The Commission adopted the Center for Medicare and Medicaid payment policies relating to coding, billing, and reporting as well as payment policies that affect utilization of services, applicable to all dates of service on or after 08/01/03. In the Physical Medicine & Rehab manual (PM&R) and Local Coverage Determinations policy (LCD a usual physical medicine session is defined as 30-45 minutes for treatment provided in a home or office setting depending on the severity of the patient's condition. Also noted in the guidelines were statements advising that the medical necessity for an unusual length of time must be documented as described in the "Documentation Requirements" section of this policy and it is usually not medically necessary to have more than one treatment session per discipline. The documentation attached does not give justification for exceeding the usual length of time established in the above referenced guideline. The Office allowed reimbursement for 45 minutes of therapy for dates of service 10/28/05, 11/2/05, 11/4/05, 11/7/05, 11/9/05, 11/11/05, 11/14/05, 11/16/05, 11/21/05, 11/22/05, 11/23/05, 11/28/05, 11/29/05 and 12/1/05 in dispute in accordance with the Medicare guidelines. Therefore the Office will maintain denial of additional reimbursement for CPT codes 97110 for 505, as exceeding the usual length of a treatment session without clinical justification."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
10/28/05	97110	N/A	$35.86	$0.00
11/2/05	97110	N/A	$35.86	$0.00
11/4/05	97110	N/A	$71.72	$0.00
11/7/05	97110	N/A	$35.86	$0.00
11/9/05	97110	N/A	$35.86	$0.00
11/11/05	97110	N/A	$71.72	$0.00
11/14/05	97110	N/A	$35.86	$0.00
11/16/05	97110	N/A	$35.86	$0.00
11/21/05	97110	N/A	$71.72	$0.00
11/22/05	97110	N/A	$35.86	$0.00
11/23/05	97110	N/A	$35.86	$0.00
11/28/05	97110	N/A	$35.86	$0.00
11/29/05	97110	N/A	$71.72	$0.00
12/1/05	97110	N/A	$35.86	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.202 sets out the medical fee guidelines for professional services rendered on or after August 1, 2003.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 11/16/05, 12/5/05 and 12/13/05 for dates of service 10/28/05, 11/2/05, 11/4/05, 11/7/05, 11/9/05, 11/11/05, 11/14/05, 11/16/05, 11/21/05, 11/22/05, 11/23/05, 11/28/05, 11/29/05 and 12/1/05

- 505 – Maximum units exceeded, payment adjusted.
- W1 – Workers' Compensation state fee schedule adj.

Explanation of benefits dated 5/31/06, 6/5/06 and 6/6/06 for dates of service 11/2/05, 11/4/05, 11/7/05, 11/9/05, 11/11/05, 11/14/05, 11/16/05, 11/21/05, 11/22/05, 11/23/05, 11/28/05, 11/29/05 and 12/1/05

- B13 – Payment for service may have been previously paid
- W4 – No additional payment allowed after review
- 18 – Duplicate claim/service
- 505 – Maximum units exceeded, payment adjusted
- R1 – Duplicate billing

Issues

1. Does the submitted documentation support the services billed under CPT code 97110?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT code 97110. The description of this code is as follows: Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility. The AMA further clarifies that CPT code 97110 is a time based code and the physician or therapist is required to have direct (one-on-one) patient contact. Pursuant to rule §134.202(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. The documentation the requestor submitted to support the charges is reviewed. The documentation supports the types of therapeutic exercises but does not support the length of time spent on each of the therapeutic exercises. Therefore, reimbursement to the requestor for CPT code 97110 is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		12/30/10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.